 Health Questionnaire

All information is strictly confidential, and will be kept on paper only, under key in a file.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age group:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 18 - 25 | 26-35 | 36 - 45 | 46-55 | 56-65 | >66 |

Have you done yoga before? If yes, what type and for how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the main reason for you to do yoga?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which aspects of Yoga interest you most:

|  |  |  |
| --- | --- | --- |
| 1. Physical postures (asanas) | 1. Breathing exercise | 1. Yoga Philosophy |
| 1. Relaxation | 1. Meditation | 1. Other (specify) |

Do you have any of the conditions below:

|  |  |  |
| --- | --- | --- |
| High Blood pressure | Yes/No | If Yes, pls give details |
| Low Blood Pressure (fainting) | Yes/No |  |
| Arthritis | Yes/No |  |
| Diabetes | Yes/No |  |
| Epilepsy | Yes/No |  |
| Heart Problems | Yes/No |  |
| Asthma | Yes/No |  |
| Detached retina / other eye problems | Yes/No |  |
| Recent fractures/sprains | Yes/No |  |
| Recent Operations | Yes/No |  |
| Back problems | Yes/No |  |
| Knee problems | Yes/No |  |
| Neck Problem | Yes/No |  |
| Are you pregnant? | Yes/No |  |
| Any other condition that might affect mobility or a yoga practice? | Yes/No |  |

I take Full responsibility of my health during the yoga classes, including any injuries. I will inform my yoga teacher if any medical condition changes

|  |  |
| --- | --- |
| Signed | Date |